Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) E		
			71. 201251110	* Annabig graphes does not a recovered to be annoted to be a recovered to be a recovered to the second to be a recovered to the second to the	С	
		IL6006175	B. WING		09/23/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COMMU	NITY NURSING & REI	1AB CIR	TH MILL ST LLE, IL 605			
(X4) ID	NAPERVILLE, IL 60563 (4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)					
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		
S 000	00 Initial Comments		S 000			
	Complaint Investigation #1575190/IL80281					
S9999	999 Final Observations		S9999			
	Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following					
Anne de como de						

	procedures d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to					
	assure that the resic as free of accident h	lents' environment remains azards as possible. All				
	nursing personnel sl	nall evaluate residents to see				
•	and assistance to pr	event accidents.				
**************************************	Section 300,3240 At	ouse and Neglect		Attachment		
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident		Statement of Licensur	e Violations			
: •	These requirements	were not met as evidenced		A Andags start.		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/05/15

9NIT11

PRINTED: 10/29/2015 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER:	A. BUILDING	Victoria de la constanta de la	COMF				
						С			
		IL6006175	B. WING		09/2	09/23/2015			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE					
COMMU	1136 NORTH MILL STREET								
	COMMUNITY NURSING & REHAB CTR NAPERVILLE, IL 60563								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE			
S9999	Continued From pa	ge 1	S9999						
	by:		* Manufacture 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1						
	•	and record review the facility				The state of the s			
		fe care to prevent a fall which	Deli constitui						
	resulted in a fractur	e. This applies to R1, one of	ancia continua						
		wed for falls in the sample of	organization of the second of						
	three.		TO THE PERSON NAMED IN COLUMN TO THE						
	The findings include: According to the MDS (minimum data set) dated 08/03/15 in the medical record R1 requires extensive assistance for bed mobility with 2 plus persons to assist. According to an incident report dated September 18, 2015, R1 was being provided morning care by E1, CNA, (Certified Nurses Aid) without the assistance of another staff member, E1's								
						-			
				TO THE PROPERTY OF THE PROPERT					
				of the second					
				OVER THE TABLE TO THE TABLE THE TABL					
	statement noted while giving R1 a bed bath E1 rolled R1 away from her. R1 rolled out of the bed falling to the floor ending up on her back. R1 complained of right hip pain and was sent to the hospital for further assessment. X-rays completed at the hospital found a fracture through the greater trochanter of the proximal right femur.								
					la de la companya de				
					1				
	of the hin was norfe	ospital where surgical repair			ma p. vido Audicina	į			
	2015 F2 DON /Dire	rmed. On September 22, ector of Nursing) stated R1							
	should have been a	ssisted by more than one staff				[
	member while care	was being given. E2 stated			1				
	E1 was remorseful a	and knew she was wrong by	and the state of t						
	not asking another s	staff member to help her with				CONTRACT AND			
	R1's care. E3, ADOI	N (Assistant Director of							
		ed in her statement the							
į	following, " Asked (CNA (E1) specifically if	American Control of the Control of t		1				
		the room at the time and she							
		myself. I'm sorry. " "							
	was notified by the f	ian stated on 09/23/15 he			1	l			
	Occurred 71 said he	acility when the incident is currently seeing R1 at the							
	hospital and was aw	are R1 had been given			!				
hospital and was aware R1 had been given morning care by only one staff person when the					**************************************				
	fall incident occurred	I. E1 said based on R1's	e endalografia						

9NIT11

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED		
						С		
IL6006175		L		09/2	09/23/2015			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY NURSING & REHAD CTB 1136 NORTH MILL STREET								
COMMUNITY NURSING & REHAB CTR 1136 NORTH MILL STREET NAPERVILLE, IL 60563								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
S99 9 9	Continued From page 2		S9999					
	clinical condition an have been receiving member when the f (B)	d assessments she should g care by more than one staff all occurred.						
THE THE PERSON PARTY								
The section and the section of the								
		OCCUPATION AND AND AND AND AND AND AND AND AND AN						
		TO CONTINUE TO THE PARTY OF THE						
4		The state of the s						
		TO THE PROPERTY AND A STATE OF	:					
		The state of the s			7			

Illinois Department of Public Health

9NIT11